Reviewer: Ifije Ohiorhenuan, MD, PhD — board-certified, fellowship-trained spine neurosurgeon
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⚠️ **SAMPLE — ILLUSTRATIVE ONLY.** This is a fictional example created to show what a SpineClarity review looks like. The patient, symptoms, and imaging findings are invented. It is **not medical advice** and does not describe a real person.

Bottom line

Based on the report and symptoms provided, the finding most likely to explain the right thigh and shin pain is the **severe right L4–L5 foraminal narrowing** affecting the **L4 nerve**. Based on the information provided, this does not sound like an emergency — but a spine evaluation is reasonable, especially if symptoms persist or any weakness worsens.

- **Most relevant finding:** Right L4–L5 foraminal narrowing
- **Less likely to explain the leg pain:** L5–S1 disc degeneration, without high-grade nerve compression
- **Useful next question:** Is the L4–L5 slip stable on flexion–extension X-rays?

The rest of this review explains how we got there, what to discuss with your clinician, and when to seek care urgently.

What you told us

- **Age / sex:** 58-year-old (fictional)
- **Main symptoms:** Right-sided lower back pain with pain running down the **front of the right thigh** toward the **inner knee and shin** for about 8 weeks. Occasional sense that the **right knee "gives way"** on stairs. No numbness in the groin or saddle area. No problems with bladder or bowel control.
- **Pattern:** Worse with standing and walking; somewhat better sitting or leaning forward.
- **Already tried:** Anti-inflammatory medication and activity modification, with limited relief.
- **Your question:** *"My report uses scary words — a slipped vertebra and 'severe' narrowing. Do I need surgery, and is this an emergency?"*
- **Red-flag screen:** None of the urgent warning signs reported (see the last section).

Your MRI report, in plain language

Here are the main phrases from your report, translated:

Your report said	What that means
Grade 1 anterolisthesis of L4 on L5	The L4 vertebra has slipped **slightly forward** over the L5 vertebra beneath it. “Grade 1” is the **mildest** of four grades — less than about a quarter of the way.
Severe right neural foraminal narrowing, L4–L5	On the **right**, the small tunnel where the **L4 nerve exits** the spine is **severely narrowed**. That nerve can be pinched as it leaves.
Moderate left foraminal narrowing, L4–L5	The same tunnel on the **left** is **less** narrowed (moderate).
Facet arthropathy, ligamentum flavum thickening	**Arthritis** of the small joints at the back of the spine, plus **thickening of a ligament** — both add to the narrowing.
Severe disc degeneration, L5–S1, with desiccation, height loss, Type II Modic changes	The **lowest disc** (between L5 and the sacrum) is badly **worn**: dried out, flattened, with long-standing changes in the bone next to it. This is **wear-and-tear**.
Broad-based disc bulge, L5–S1; no high-grade nerve root impingement	The worn disc bulges evenly but is **not significantly pinching a nerve**.

In one paragraph: The report describes two separate findings. At **L4–L5**, a mild forward slip plus arthritis and ligament thickening have **severely narrowed the right-side tunnel** that the L4 nerve travels through. At **L5–S1**, the disc is **severely worn**, but the report notes it is **not pinching a nerve**. These are very different findings, and — as you’ll see — they may relate to different parts of how you feel.

How your symptoms may relate to these findings

The symptom pattern you described — right-sided pain in the **front of the thigh** reaching toward the **inner knee and shin** — is **commonly associated with the L4 nerve**. The report describes severe narrowing exactly where the **right L4 nerve exits** the spine (the **right L4–L5 foramen**), and the small forward slip of L4 narrows that tunnel further. The right knee occasionally giving way would also be consistent with the L4 nerve, which helps power the muscle that straightens the knee.

When the side, the level, and the symptom pattern line up like this, a finding is **more likely to be clinically relevant** than an incidental change — which makes the right L4–L5 foraminal narrowing worth discussing with your treating clinician. Confirming the actual source of pain still requires an in-person evaluation by a clinician who can examine you.

The **L5–S1 worn disc is a different story.** Severe disc degeneration is one of the **most common** findings on a lumbar MRI, and it is frequently seen in people who have **no back pain at all** — it becomes more common with every decade of life. On its own, a worn L5–S1 disc that isn’t pinching a nerve would not typically cause leg pain in an L4 pattern. It **may contribute to back pain**, but it would **not typically explain leg symptoms in this pattern.** This is exactly why the word “severe” on a report

doesn't automatically mean "the cause" — the real question is always *which finding matches your symptoms.*

Is a surgical consultation reasonable to discuss?

Putting it together — severe foraminal narrowing, a grade 1 slip, and leg symptoms that match — **a consultation with a spine surgeon is reasonable to discuss.** I want to be clear about what that does and does not mean:

- It does **not** mean you need surgery.
- It does **not** mean this is an emergency. Nothing you've described includes the urgent warning signs listed at the end.
- **Most people with these findings start with non-surgical care.**

A surgical consultation is appropriate simply because this is a **structural problem a surgeon is well-suited to evaluate** — particularly if non-surgical measures don't help, or if any leg weakness develops. Severity on imaging should **guide** that conversation, not dictate surgery.

If surgery ever did come up, the slip is the reason there are two possible approaches:

- **Decompression** — making more room for the pinched nerve (for example, opening the narrowed tunnel).
- **Decompression *plus* fusion** — also stabilizing the slipped level so it can't move.

Which one is appropriate depends largely on whether your slip is **stable or unstable**, and on your pain pattern. Understanding that distinction is the single most useful thing to walk into a surgical visit already knowing — which leads to the next point.

Could additional testing help?

One specific test is worth asking about: **standing X-rays of your lower back taken while you bend forward and backward** (flexion–extension views). An MRI is taken lying still, so it can show that a slip *exists* but not whether it *moves*. If the L4–L5 slip stays put when you bend, it's considered **stable**; if it shifts, that's **instability** — and that finding often changes the surgical plan (it's central to the decompression-versus-fusion decision above). This is a simple, low-cost test that an MRI cannot replace.

Non-surgical options people commonly discuss with their doctors

For a picture like this, options patients often raise with their physicians include:

- **Activity modification and physical therapy** focused on core and lower-back **stabilization** — often with a forward-leaning bias, which tends to open the narrowed tunnels.
- **Oral medication** (anti-inflammatories, or nerve-pain medications) **if your physician thinks they're appropriate.**

- **An image-guided injection** of steroid around the affected nerve. Your physician may discuss whether a **targeted injection around the right L4 nerve** is appropriate. An injection like this can do two things: relieve pain, **and** help confirm the source — if numbing that specific nerve relieves the leg pain, it points toward the L4–L5 tunnel as the likely culprit.

These are options to **discuss**, not a treatment plan — your treating clinician decides what's right after examining you.

Questions to ask your physician or surgeon

- Which finding do you think is causing my leg pain — the **L4–L5 foraminal narrowing**, the slip, or something else?
- Is my **L4–L5 slip stable, or does it move** when I bend? Do I need **flexion–extension X-rays**?
- If I needed surgery, would it be a **decompression alone, or also a fusion** — and why?
- How **urgent** is this? What would make surgery **necessary** rather than optional?
- Is it reasonable to try **physical therapy or a targeted injection** first?
- What signs should make me seek care **sooner**?

A checklist for your appointment

- [ ] Bring the **actual MRI images** (on disc or shared through a portal), not only the written report.
- [ ] Bring a short **timeline**: when it started, how it's changed, and what makes it **better or worse**.
- [ ] List **everything you've tried** and whether it helped.
- [ ] Note any **weakness, numbness, or change in how far you can walk**.
- [ ] Write down your **top three questions** ahead of time.

When to seek care urgently (red flags)

Some symptoms need urgent evaluation **regardless of what an MRI report says.** Seek emergency care right away — don't wait for your specialist appointment — if you develop any of the following:

- **New or worsening leg weakness** (for example, a foot dragging, or the knee giving out repeatedly)
- **Loss of bowel or bladder control,** or new difficulty urinating
- **Numbness in the groin, inner thighs, or saddle area**
- **Fever with severe back pain**
- **Severe, unrelenting night pain, or unexplained weight loss**
- **A recent major injury or fall**

Important scope and limits

This review is an **educational explanation** based only on the information and the report you provided. It is **not a diagnosis, not a treatment plan, and not a substitute for an in-person evaluation** by a

clinician who can examine you and review your complete history and images. Diagnosis and treatment decisions should be made with your treating clinician. SpineClarity is not emergency care.

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